STATE OF MAINE

BOARD OF COMPLEMENTARY HEALTH CARE PROVIDERS

Application for Licensure

Acupuncturist

Naturopathic Doctor

Naturopathic Acupuncture Specialty Certification

Department of Professional and Financial Regulation
Office of Licensing and Registration
35 State House Station
Augusta, ME 04333-0035

Office Telephone: (207) 624-8689
TTY/HEARING IMPAIRED: 1-888-577-6690 Fax Line: (207) 624-8637
email: voni.a.eames@maine.gov
Office located at: 122 Northern Avenue, Gardiner, Maine 04345

Published under appropriation 01402A4450012 Revised 01/05
Physical address 122 Northern Ave., Gardiner, ME 04345
Website: www.maineprofessionalreg.org

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
OFFICE OF LICENSING AND REGISTRATION
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035

John Elias Baldacci
GOVERNOR

ANNE L. HEAD
DIRECTOR

ACUPUNCTURE
PROSPECTIVE APPLICANT --- APPLICATION CHECKLIST

The following is a checklist intended to assist with preparing the information that must be submitted with your application. You are advised to read the rules carefully to insure that you are meeting the requirement of rule. *This checklist is not intended to replace your responsibility to refer to the laws and rules.* Separately sent material will not be accepted. **You must submit a complete application packet as described below.** To expedite the review process and granting of licenses, the Board of Complementary Health Care Providers has authorized Office staff to perform the review and approval process. ☐**The criminal history check form must be included with all applications regardless of the method of application.**

The complete application packet will include the following as described in the 3 various methods licensure:

☐*CHAPTER 3.1 APPLYING WITH BACCALAUREATE DEGREE*

☐Baccalaureate Degree

☐Official Acupuncture School Transcript of 1,000 acupuncture classroom hours

☐Official verification of 300 acupuncture hours of clinical experience

☐Official copy of the NCCAOM Certification

☐*CHAPTER 3.2 APPLYING AS REGISTERED NURSE OR PHYSICIAN'S ASSISTANT*

☐Verification of Licensure as Registered Professional Nurse, OR
☐Verification of Completion of Training Program and Examination as Physician's Assistant

☐Official Acupuncture School Transcript of 1,000 acupuncture classroom hours

☐Official verification of 300 acupuncture hours of clinical experience

☐Official copy of the NCCAOM Certification

☐*CHAPTER 3.3 EXPERIENCED-BASED ACUPUNCTURIST (Prior to 8/9/89)*

☐6 Months Practice as Acupuncturist in Maine as of 8/9/89
☐Official Acupuncture School Transcript of 1,000 acupuncture classroom hours
☐Official verification of 300 acupuncture hours of clinical experience
☐Official copy of the NCCAOM Certification

Application forms or supporting documents that have been altered, defaced or compromised will not be accepted.

Please contact Voni Eames at (207) 624-8689 or email at voni.a.eames@maine.gov if you have any questions.

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SPECIALTY CERTIFICATION

FOR NATUROPATHIC DOCTORS TO PRACTICE ACUPUNCTURE

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The complete application packet will include the following:

- ☐ An official transcript verifying 1,000 of hours of acupuncture classroom instruction. The transcript must show the number of hours of classroom instruction
- ☐ Verification of 300 hours of supervised clinical experience in acupuncture as describe in rules
- ☐ NCCAOM certification: Must be an official copy of NCCAOM certificate or written verification from NCCAOM
- ☐ Specialty Certification fee

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NATUROPATHIC DOCTOR
PROSPECTIVE APPLICANT --- APPLICATION CHECKLIST

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Separately sent material will not be accepted. **You must submit a complete application packet as described below.** To expedite the review process and granting of licenses, the Board of Complementary Health Care Providers has authorized Office staff to perform the review and approval process.

The complete application packet will include the following:

- ☐ An *official transcript* which contains the school seal from an approved naturopathic medical college.
- ☐ *NPLEX Exam*. Evidence of having passed a competency-based examination covering the appropriate naturopathic subjects, including basic and clinical sciences, homeopathy and minor surgery.
- ☐ *Two signed original reference letters* addressing good ethical and professional conduct from two of any of the following licensed doctors: naturopathic doctor, osteopathic doctor or medical doctor.
- ☐ *Verification of your licensure status* from another State where you are currently or have been licensed, if applicable.
- ☐ *Fees.* Application fee, license fee and criminal history record check fee. All fees are nonrefundable.

Application forms or supporting documents that have been altered, defaced or compromised will not be accepted.

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FOR OFFICE USE ONLY

44501446	$75.00
44501442	$325.00
44501422	$325.00
44501423	$50.00
44502619	$15.00

APPLICATION FOR LICENSURE

FEE: Please pay the required fee as indicated. Make check payable to **TREASURER, STATE OF MAINE**. For your convenience, our office accepts payment by credit card. You must complete and submit a credit card authorization form.

Please check the appropriate box for the license you are applying. Please refer to the rules for licensure read carefully to make sure you submit all required materials with your application. **Failure to do so may cause a delay in the processing of your application.**

☐ Initial Application Fee (1446) $ 75.00 (NON-REFUNDABLE)
☐ Criminal History Record Check $ 15.00

Please check the appropriate box for which you are applying:

☐ Acupuncturist (1421)	$325.00	TOTAL FEE DUE	**$415.00**
☐ Naturopathic Doctor (1422)	$325.00	TOTAL FEE DUE	**$415.00**
☐ Naturopathic Acupuncture Specialty Certification (1423)	$ 50.00	TOTAL FEE DUE	**$140.00**

Once approved for licensure, please be advised that your initial license may be for a period less than twelve months depending on when you file your application for licensure. Your first license will expire with the next renewal period expiring October 31st. The license renewal fee is $325.00.

NAME OF APPLICANT: _____
FIRST MI LAST

ANY OTHER NAMES USED:_____

ADDRESS: _____
STREET CITY STATE ZIP

CONTACT ADDRESS:
(If different from above)

_____
STREET CITY STATE ZIP

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

CONTACT PHONE: ( ) _____ - _____

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PLACE OF PROFESSIONAL PRACTICE:
_____

MAILING ADDRESS: _____

Are you licensed as an Acupuncturist in any other state? ☐ YES ☐ NO
** If YES, please list the state(s), license/certificate number(s) and expiration date(s) below:

_____

Are you licensed as a Naturopathic Doctor in any other state? ☐ YES ☐ NO
** If YES, please list the state(s), license/certificate number(s) and expiration date(s) below:

_____

** You must also send the enclosed **Verification of Licensure** form to any other state board where you hold or have held an Acupuncture license or a Naturopathic Doctor license. Please follow directions on the form.

Please request that the state completing the **Verification of Licensure** attach a copy of the Acupuncture or Naturopathic Doctor Licensing Board's enabling statutes and rules to be sent to the **Maine State Board of Complementary Health Care Providers** at the address listed on the reverse side of this form.

For Acupuncture:
Are you **NCCAOM** certified? ☐ YES ☐ NO

If YES, Certificate Number: _____ Expiration Date: _____

For Naturopathic Doctor: Have you passed both the basic science and clinical components of the **NPLEX** examination? ☐ YES ☐ NO

If YES, date of basic science and date of clinical examinations: _____

ACUPUNCTURE OR NATUROPATHIC TRAINING

INSTITUTION: _____

ADDRESS: _____

DEGREE GRANTED: _____ DATE AWARDED: _____

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PERSONAL DATA

Check appropriate response to the questions. Any **YES** response must be fully explained by written statement on a separate sheet of paper, signed and dated, and submitted with your application.

HAVE YOU EVER:

1. Had any state or territory of the U.S. or province/territory of Canada EVER deny your application for any type of professional license, certificate or registration, or taken any disciplinary action against the license issued to you in that jurisdiction (including, but not limited to, warning, reprimand, fine, suspension, revocation or restrictions in permitted practice, probation with or without monitoring)?

☐ YES ☐ NO

2. Left a regulatory jurisdiction while allegations were pending? ☐ YES ☐ NO

3. Been denied registration by the U.S. Drug Enforcement Administration (DEA) or has your DEA Registration ever been modified, restricted, suspended or revoked? Has any state or province denied, restricted, modified, suspended or revoked your state permit to prescribe or dispense controlled substances? ☐ YES ☐ NO ☐ N/A

4. Received a sanction from Medicare or from a state Medicaid program? ☐ YES ☐ NO

5. Suffered from any psychiatric or addictive disorder that would impair or require limitations on your functioning as a practitioner or resulted in an inability to engage in your professional practice for more than 30 days? ☐ YES ☐ NO

6. Been indicted, arrested or convicted of any criminal offense (including motor vehicle offenses, but not including minor traffic or parking violations)? ☐ YES ☐ NO
(If YES, please attach a detailed explanation and provide a copy of the court judgment/disposition.)

7. Had hospital or similar health care institution privileges which had previously been granted to you suspended, restricted or withdrawn involuntarily; or have you ever voluntarily surrendered privileges or resigned from staff membership while under peer review? ☐ YES ☐ NO ☐ N/A

8. Been disciplined by a professional society or resigned while an accusation was pending?

☐ YES ☐ NO

9. Had a pending claim or suit alleging malpractice liability, a claim settlement by negotiation/arbitration or judgment by a court in a claim of medical malpractice liability in which you are/were named as a defendant with any degree of liability <u>including</u> "nuisance" suits and including settlements made by your insurance company/representatives without your express consent?

☐ YES ☐ NO

10. Applied for hospital or similar health care institution privileges which were denied?

☐ YES ☐ NO

11. Do you intend to practice acupuncture or naturopathic medicine within the State of Maine at a Maine hospital? ☐ YES ☐ NO

Notice regarding Social Security Number Disclosure

The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRSA section 175 as authorized by the Tax Reform Act of 1976 (42 USC section-405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRSA section 191.

Notice regarding Public Information

This application is a public record for purposes of Maine's Freedom of Access Law, 1 MRSA §401, et seq. Public records must be made available to any person upon request. Information that you supply as part of this application (except your Social Security number) is public information. Other licensing records to which this information may later be transferred are also considered public records. Where permitted by law, your name, license number, contact address and other information listed on this application may be posted on the State's website.

The undersigned applicant further authorizes all law enforcement agencies and officials thereof to release to the Maine State Board of Complementary Health Care Providers any and all criminal history record information pertaining to said applicant.

Pursuant to 5 M.R.S.A. §5301-5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Licensing and Registration **requires** a criminal history records check as part of the application process for each application filed with this office.

Public Law Chapter 401, sec. W-1, amends Title 25 §1541, sub-§6 to allow the State Bureau of Identification to charge a fee to government organizations for services provided. As of October 1, 1999 all criminal background checks of individuals are subject to a fee as determined by the Commissioner of Public Safety, which shall be $15.00 as of May 1, 2003.

By my signature, I affirm that all information provided in connection with this application is true to the best of my knowledge and belief, with the understanding that any omissions, inaccuracies or failure to make full disclosure may be deemed sufficient reason to suspend or recommend revocation of a license issued by the Board. I further authorize all law enforcement agencies and officials thereof to release to the Board any and all criminal history record information pertaining to myself.

_____ _____

SIGNATURE OF APPLICANT DATE

DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BOARD OF COMPLEMENTARY HEALTH CARE PROVIDERS
35 State House Station, Augusta, ME 04333
Telephone: (207) 624-8689 Hearing Impaired: 1-888-577-6690 Fax: (207)624-8637

VERIFICATION OF LICENSURE FOR NATUROPATHIC MEDICINE

I am applying for licensure to practice as a Naturopathic Doctor in the State of Maine. The Maine Board of Complementary Health Care Providers requests verification of registration from **each** state wherein I hold or have held registration. This is your authority to release any information in your files, favorable or otherwise, directly to the Maine Board of Complementary Health Care Providers.

To be completed by the **APPLICANT**:

Name _____

Address _____

License # _____ Date Issued _____

Applicant's Signature _____

To be completed and returned by the **LICENSING BOARD** along with a copy of licensing requirements. Please return to the above address.

Name of Licensee _____

License # _____ Date Issued _____

Has the candidate passed the NPLEX examination? _____ Date Passed _____

Is applicant currently licensed in this state? _____ Date of expiration _____

If not currently licensed, when did license expire? _____

Is the licensee in good standing? _____ If no, please attach detailed explanation.

Has your state ever imposed discipline against this individual? _____

Is any action pending against applicant? _____ If yes, please attach detailed explanation.

Printed Name _____ Title _____

State Official Signature_____ Date _____

State _____

STATE SEAL

Rev 3/99

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VERIFICATION OF LICENSURE FOR ACUPUNCTURE

I am applying for licensure to practice as an Acupuncturist in the State of Maine. The Maine Board of Complementary Health Care Providers requests verification of registration from **each** state wherein I hold or have held registration. This is your authority to release any information in your files, favorable or otherwise, directly to the Maine Board of Complementary Health Care Providers.

To be completed by the **APPLICANT**:

Name _____

Address _____

License # _____ Date Issued _____

Applicant's Signature _____

To be completed and returned by the **LICENSING BOARD** along with a copy of licensing requirements. Please return to the above address.

Name of Licensee _____

License # _____ Date Issued _____

Has the candidate passed a Board approved examination? _____

Is the licensee NCCAOM certified? _____

Is applicant currently licensed in this state? _____ Date of expiration _____

If not currently licensed, when did license expire? _____

Is the licensee in good standing? _____ If no, please attach detailed explanation.

Has your state ever imposed discipline against this individual? _____

Is any action pending against applicant? _____ If yes, please attach detailed explanation.

Printed Name _____ Title _____

State Official Signature_____ Date _____

State _____

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JOHN ELLIAS BALDACCI
GOVERNOR

ANNE L. HEAD
DIRECTOR

AUTHORIZATION OF CREDIT CARD PAYMENT

Fees owed to this Department may be paid by the use of a credit card. If you wish to pay your fee(s) with your credit card, please complete this form and send it with your application. Payment through credit cards will not be processed without this authorization form.

Name: **(applicant fees being paid for)**		
***Mailing Address*:** **(applicant fees being paid for)**		
City:	***State:***	***Zip Code:***
County:	***Telephone #:***	
Name of cardholder: **(if other than applicant)**		
***Mailing Address*:** **(if other than applicant)**		
City:	***State:***	***Zip Code:***

I authorize the State of Maine, Department of Professional and Financial Regulation, Office of Licensing and Registration to charge my:

☐ **Visa** ☐ **MasterCard**_____
Card number

Expiration date: _____/_____/_____ **in the amount of: $**_____

Signature: _____**Date:** ____/_____/_____

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